100TH CONGRESS
2D SESSION

H. R. 4455

To amend the Social Security Act to establish a new program to provide for the health care needs of the elderly, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 26, 1988

Mr. ROSE introduced the following bill; which was referred jointly to the Committees on Energy and Commerce and Ways and Means

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A BILL

To amend the Social Security Act to establish a new program to provide for the health care needs of the elderly, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FINDINGS.

Congress finds the following:

(1) Without substantial reform, the Medicare program will go bankrupt. The currrent projection of the Medicare trustees is that the program will be bankrupt in 2002.

(2) Those people eligible for Medicare in the year 2002 and after have no assurance of the availability of

promised resources to provide for health care coverage, regardless of the substantial tax burden they will have incurred by that time to fund the Medicare program.

(3) Total Medicare benefit payments have grown from $4,600,000,000 in 1967, the first full year of its operation, to $62,900,000,000 in 1984, and are now approaching $80,000,000,000.

(4) In the next 50 years, the population over age 65 will more than double and the population over age 85 will more than triple.

(5) The ratio of workers to elderly will decrease from approximately 4:1 in 1990 to approximately 2:1 in 2025.

(6) As the proportion of older people in the population increases, the requirements for acute and long-term care will increase.

(7) Although comprising 11 percent of the total population, elderly patients make 30 percent of all patient visits to office-based physicians.

(8) Forty percent of total hospital inpatient days are used by elderly patients. In 1978, short-stay hospital admissions for persons age 65 and over were approximately 350 per thousand population, while for those under 65 the figures were about 132 per thou-

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sand population. Older patients have an average length of stay 76 percent greater than younger adults.

(9) The elderly occupy 90 percent of nursing home beds.

(10) Persons over age 65 incurred 3.5 times the per capita health care expenditures of persons under age 65. Almost two-thirds of these expenditures are covered through Medicare and Medicaid.

(11) Virtually all private non-governmental nursing home expenditures, 97 percent, are not covered by private insurance.

(12) Between 60 percent and 80 percent of the long-term care that the disabled elderly receive in the community is provided informally by a spouse, other relatives, and/or friends. The presence of a spouse and/or children is the most important factor in determining whether or not a disabled elderly patient will enter a nursing home.

(13) To meet present and future health care needs for the elderly and to assure access to quality care for all beneficiaries, there must be a shift from the current pay-as-you-go system to a fiscally sound, prefunded program.

(14) Access to quality health care for the elderly should be assured.

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(15) All beneficiaries should have access to the same range of program benefits, and should share in the program's cost in a way which encourages responsible use of medical resources. There should be a cost-sharing limit to protect the patient from catastrophic medical expenses.

(16) Access should be assured for necessary medical services. Coverage for necessary care should be sufficiently flexible to make appropriate accommodations for new medical therapies and technology. Expansion of benefits other than for medical services should not divert resources.

(17) Legitimate regional variations in health care costs must be recognized in setting distribution amounts for the purchase of health care plans.

(18) Health care plans for the elderly should encourage delivery of services in cost-effective settings consistent with the appropriate quality of care.

(19) The new program will continue to honor commitments to assure access to and provide coverage for medically necessary services made to current elderly Medicare beneficiaries. Payment for services should be sufficient to assure reasonable access to those services.

(20) The existing Medicare financing mechanism is flawed. Its pay-as-you-go system creates an intergenerational transfer of resources and is adversely affected by the deteriorating worker-to-beneficiary ratio. Other major flaws of the current system include its lack of catastrophic protection, its lack of equitable relation to beneficiary income, and burdensome government administration.

(21) The creation of a new, fiscally sound program to provide for the health care needs of the elderly could immediately eliminate the Federal Government's general revenue obligation to the Federal Supplementary Medical Insurance Trust Fund which totaled $18,000,000,000 in 1985.

(22) A program should be established for the elderly that provides universal eligibility and protects access to health care through fiscally and actuarially sound financing.

(23) Future tax rates for a program constructed on sound financial and equitable principles will be considerably less than the combined payroll, general revenue taxes, and premium costs that would be necessary to fund the current Medicare program on a fiscally sound basis.

(24) The age of eligibility for federally funded health care for the elderly should recognize changing trends in terms of the employment, health status, and longevity of our citizens.

(25) Cost sharing for individuals based on financial ability to pay is necessary to ensure the fiscal integrity of any Federal health care program.

(26) Federal health care programs for the elderly should assure freedom of choice of physician, provider, or system of health care delivery.

SEC. 2. HEALTH CARE COVERAGE FOR THE ELDERLY.

The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—HEALTH CARE COVERAGE FOR THE ELDERLY

"PROHIBITION AGAINST FEDERAL INTERFERENCE

"SEC. 2101. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

"FREE CHOICE BY PATIENT GUARANTEED

"SEC. 2102. Any individual entitled to covered benefits under this title may obtain these health services from any institution, agency, person, or system qualified to participate under this title if such institution, agency, person, or system undertakes to provide the beneficiary with such services.

"INDIVIDUAL OPTIONS

"SEC. 2103. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

"PART A—ELDERLY HEALTH FINANCING AUTHORITY

"CREATION; MEMBERSHIP; COMPENSATION; AND EXPENSES

"SEC. 2111. There is hereby established an Elderly Health Financing Authority which shall be responsible for the operation of a program to assure health care coverage for the elderly. The Elderly Health Financing Authority shall be governed by a Board of Governors (hereafter in this title referred to as the 'Board'). The Board shall be composed of 9 members, appointed by the President, by and with the advice and consent of the Senate, for terms of 14 years, except as hereafter in this title provided. In selecting the members of the Board, the President shall have due regard to a fair representation of the public, including representatives of business, labor, physicians, hospitals, payors, and the beneficiary

population, with due regard for regional divisions within the United States. Due to the substantial health care responsibilities of the Board, at least 3 members must be physicians.

"TERMS OF MEMBERS; OFFICES

"SEC. 2112. Upon the initial appointment of the Board, the terms of members shall be varying lengths of time at the discreation of the President at the time of appointment. The initial terms shall provide for the expiration of the term of not more than 1 member in any 2-year period, with each intial members serving at least 3 years. Thereafter, each member shall hold office for a term of 14 years from the expiration of the term of his predecessor, unless sooner removed for cause by the President. One member shall be designated by the President, by and with the advice and consent of the Senate, to serve as Chairman of the Board for a term of 4 years, and 1 member shall be designated by the President, by and with the consent of the Senate, to serve as Vice Chairman of the Board for a term of 4 years. The Chairman of the Board, subject to the Board's supervision, shall be the Board's active executive officer. Each appointed member of the Board shall, within 15 days after notice of approval by the Senate, make and subscribe to the oath of office. Upon the expiration of their terms of office, members of the Board shall continue to serve until their successors are appointed and are approved by the Senate. Board members shall not be eligible for reappointment after having served a full term of 14 years.

"COMPENSATION

"Sec. 2113. The members of the Board shall devote their entire time to the business of the Board and shall each receive basic compensation at Level II of the Executive Schedule under chapter 53 of title 5, United States Code.

"INELIGIBILITY TO HOLD CERTAIN OFFICES

"SEC. 2114. The members of the Board shall be ineligible during the time they are in office, and for 2 years thereafter, to hold any office, position, or employment with any insurance entity, any financial or banking entity with which the Board invests or deposits funds, or any holding corporation with substantial interests in any such entity.

"CAUSE FOR REMOVAL

"SEC. 2115. The President shall have cause to remove a member from the Board upon a clear demonstration of that member's non-performance of duty as determined by rules and regulations of the Board, or a conflict of interest under section 2114, or upon that member's conviction for a felony or a misdemeanor directly related to the duties of the Board.

"BOARD OPERATIONS

"SEC. 2116. The principal offices of the Board shall be within the vicinity of the District of Columbia. At meetings of the Board, the Chairman shall preside. In the Chairman's absence, the Vice Chairman shall preside. In the absence of the Chairman and Vice Chairman, the Board shall elect a member to act as the presiding officer. The Board shall deter-

mine and prescribe the manner in which its obligations shall be incurred and the manner in which its disbursements and expenses shall be allowed and paid. The employment, compensation, leave, and expenses of the members and employees of the Board shall be governed solely by the provisions of this title and by the rules and regulations of the Board that are consistent with this title. Whenever vacancy on the Board shall occur, other than by expiration of term, a successor shall be appointed by the President, by and with the consent of the Senate, to fill such vacancy. Members appointed to an unexpired term shall hold office for the remainder of the term of the predecessor.

"VACANCIES DURING RECESS OF SENATE

"SEC. 2117. The President may fill all vacancies that occur on the Board during periods when the Senate is not in session by granting special commissions that shall expire 60 days after the Senate reconvenes.

"REPORTS TO CONGRESS

"SEC. 2118. The Board shall annually make a full report of its operations to the Congress.

"RECORDS

"SEC. 2119. The Board shall keep a complete record of the actions taken by the Board upon all questions of policy, including those related to its enumerated powers, and shall record therein the votes taken in connection with the determination of policies and the reasons underlying the action of

the Board and the Committees of the Board in each instance. The Board shall include in its annual report under section 2118 a full account of the actions taken during the preceding year with respect to its policies and operations. The report shall include the records required to be kept under the provisions of this section.

"ENUMERATED POWERS

"SEC. 2120. The Board shall take the following actions:

"(1) The Board shall monitor measures of change in health care and the economy, including—

"(A) the rate of increase in health care costs relative to inflation generally,

"(B) changes in life expectancy and birth rates,

"(C) developments in medical science;

"(D) patterns of health care, and

"(E) any other appropriate measures of change in health care.

"(2)(A) The Board shall make recommendations to Congress on the adequate level of health care benefits that should be offered to individuals eligible under this title by qualified health care plans, including annually reviewing and setting limits on deductibles and coinsurance,

"(B) The Board shall, every 2 years, by rules and regulations determined by the Board that are consist-

ent with this title, hold hearings and provide a mechanism for submitting written comments that will allow the public, health care providers, and other interested individuals and organizations, an opportunity to comment on the level of health care benefits that qualified health care plans should be required to offer.

"(C) The Board shall publish due notice of such hearings and provide opportunity to comment in the Federal Register with no less than a 60-day comment period.

"(3) The Board shall determine the actuarially sound premium needed to purchase adequate health care insurance and review such determination annually.

"(4) The Board shall determine the average annual contribution needed to provide a fund sufficient for purchasing health care insurance, and review such determination annually.

"(5) The Board shall propose to Congress, no later than June 1 of each year, any necessary changes in tax rates, age limits for tax contributions, or age of eligibility, as determined by the Board, based on the monitoring and annual reviews required under paragraphs (1) through (4) of this section.

"(6) The Board shall serve as trustee of funds accumulated from annual individual contributions, which

are to be distributed and invested solely by the Board in a manner not inconsistent with this title or any applicable Federal law.

"(7)(A) The Board shall provide, by rule and regulation as determined by the Board, a mechanism for insurance companies and other health plans to seek qualification of private health care benefit plans under this title, and to qualify such plans for participation under this title.

"(B) Factors the Board shall take into consideration in qualifying private health care benefit plans shall include adequate capital and reserve levels, enrollment practices, and marketing and advertising practices.

"(C) The Board shall provide for a periodic review of qualified private health care benefit plans and a mechanism, consistent with Federal law and protected rights, to disallow the qualification of a plan from participation under this title.

"(8) The Board shall distribute annual health care vouchers to eligible individuals for purchase of private health care benefit plans qualified under this title.

"(9) The Board shall delineate geographic areas of the United States and its territories with respect to

differing regional health costs, and annually set the voucher amount for each area.

"(10) The Board shall appoint an Administrator who will have responsibility for overseeing the staff and managing the resources necessary for the Board to carry out its powers and duties under this section. The Administrator shall be compensated at Level IV of the Executive Schedule under chapter 53 of title 5, United States Code.

"PART B—ELIGIBILITY

"ELIGIBILITY OF BENEFICIARIES

"SEC. 2125. Every individual who has attained the age—

"(1) of 65, prior to or during the first year after the date of the enactment of this title,

"(2) of 65 and 3 months in the second year after the date of the enactment of this title,

"(3) of 65 and 6 months in this third year after the date of the enactment of this title,

"(4) of 65 and 9 months in the fourth year after the date of the enactment of this title,

"(5) of 66 in the fifth year after the date of the enactment of this title,

"(6) of 66 and 3 months in the sixth year after the date of the enactment of this title,

"(7) of 66 and 6 months in the seventh year after the date of the enactment of this title,

"(8) of 66 and 9 months in the eighth year after the date of the enactment of this title, or

"(9) of 67 in the ninth year after the date of the enactment of this title,

shall be eligible for benefits under this title.

"PART C—ANNUAL HEALTH CARE VOUCHERS

"PURCHASE OF QUALIFIED HEALTH CARE INSURANCE

"SEC. 2131. The Administrator shall provide each individual qualified under section 2125 with an annual health care voucher, to be used solely as consideration for the purchase of a private health care benefit plan qualified by the Board as meeting the requirements of section 2151. The annual health care voucher shall be distributed to qualified individuals by the Administrator no later than September 1 of the year preceding the calendar year for which the voucher is designated to be used to purchase a qualified policy, or by 30 days prior to an individual becoming eligible to receive an initial voucher.

"NON-ASSIGNABILITY OF VOUCHER; CRIMINAL FRAUD

"SEC. 2132. Any right of a beneficiary to a voucher arising from this title shall not be assignable, nor shall any value be offered or accepted in consideration of a beneficiary's assertion or forbearance of rights to a voucher arising from this title. Violation of this section shall be considered

criminal fraud or conspiracy to commit criminal fraud under the appropriate sections of title I; of the United States Code.

"TRANSFER OF VOUCHER; BREACH OF AGREEMENT

"SEC. 2133. A beneficiary shall not transfer an annual voucher from one qualified plan to another once the beneficiary has entered an agreement with a qualified plan except upon substantiation of a complaint by the beneficiary that the insurance carrier has breached its agreement with the beneficiary by not carrying out its responsibilities under the agreement. An inquiry and report of findings based on a complaint shall be made by the Administrator within 30 days of the receipt of the complaint under rules and regulations determined by the Board. Upon substantiation of a complaint, the Board may—

"(1) require the insurance carrier to reimburse individual beneficiaries for reasonable expenses incurred as a result of the insurance carrier's breach of the agreement,

"(2) fine the insurance carrier no more than $2,000 for each incident of breach of contract, and

"(3) under rules and regulations determined by the Board, remove the insurance carrier and such carrier's plan as a qualified private health benefit plan for repeated incidences amounting to substantial nonperformance of such carrier's responsibilities under its agreements with the beneficiaries.

Upon such removal, any other insurance carrier that offers qualified plans and, under State law, is able to contract with such beneficiary shall be required to accept the voucher of a transferring beneficiary, to be valued on a pro-rated basis from the day the Board makes a determination that the health benefit plan of nonperforming insurance carrier is no longer qualified.

"EXTENSION OF AGREEMENT

"SEC. 2134. If a beneficiary, guardian of a beneficiary, or the beneficiary's estate has not entered into an agreement with an insurance carrier to apply the annual voucher by January 1 of the year for which the annual voucher is designated for use, the agreement entered into the previous year shall be deemed extended through the designated year, and each succeeding year, under the same terms, as the previous agreement subject to any changes as determined by the Board. If a beneficiary fails to enter into an agreement with an insurance carrier the previous year, the Administrator will assign the beneficiary, by lot, to enter into an agreement for minimum benefits with a qualified plan that, by State law, is able to contract with the beneficiary.

"EXECUTION OF VOUCHER

"SEC. 2135. The annual voucher shall be in such form as to allow both the beneficiary and the carrier to enter into an agreement for private health care benefit coverage under this title upon the voucher document itself, and shall be con-

structed to provide self-generating copies for the beneficiary, the insurance company, and the Administrator. The carrier shall forward the appropriate voucher copy to the Administrator upon execution of the agreement.

"CONTENT OF VOUCHER

"SEC. 2136. The annual voucher shall have printed on its face the year for which the annual voucher is designated to be used to purchase a qualified plan, the value of the voucher as determined by the Board, all rights of beneficiaries arising under this title, and all the requirements that beneficiaries must meet to be able to use the voucher.

"OPEN ENROLLMENT; PRE-EXISTING CONDITIONS

"SEC. 2137. Beneficiaries will have the right to elect health care coverage through any qualified plan offered in their State of residence. Carriers offering private health care benefit plans must maintain an open enrollment period of at least 45 days prior to January 1 of each year, and all plans must be open to new beneficiaries. All benefits set forth in section 2151 must be provided to plan enrollees regardless of pre-existing conditions. Where a health care benefit plan provides additional benefits beyond those set forth in section 2151, those benefits must be provided to enrollees regardless of pre-existing conditions and no later than one year after enrollment.

"PART D—COST-SHARING

"BENEFICIARY COST-SHARING

"SEC. 2141. Under any qualified health care benefit plan agreement, beneficiaries shall be responsible for the following amount of expenses incurred for services required under this title in a year (including those expenses incurred by the beneficiary under this title in the last 3 months prior to the designated year, but such expenses shall only apply once):

"(1) For an individual—

"(A) a deductible of $500, plus

"(i) 10 percent of annual adjusted gross income for an individual whose adjusted gross income in the taxable year ending in the previous year was at least $30,000 but not greater than $50,000, and

"(ii) 15 percent of annual adjusted gross income for an individual whose adjusted gross income in the taxable year ending in the previous year was greater than $50,000, and

"(B) coinsurance of 20 percent of expenses payable under this title, but the amount paid for such coinsurance shall not exceed $2,000 in a year.

"(2) For a married couple eligible for services payable under this title—

"(A) a deductible of $750, plus

"(i) 10 percent of annual adjusted gross income for a couple whose adjusted gross income in the taxable year ending in the previous year was at least $30,000 but not greater than $50,000, and

"(ii) 15 percent annual adjusted gross income for a couple whose adjusted gross income in the taxable year ending in the previous year was greater than $50,000, and

"(B) coinsurance of 20 percent of expenses payable under this title, but the amount paid for such coinsurance shall not exceed $3,000 in a year.

"PART E—REQUIRED BENEFITS

"CERTIFICATION OF HEALTH INSURANCE PLANS

"SEC. 2151. (a)(1) The Administrator shall establish a procedure whereby private health care benefit plans, as defined in section 2153, will be certified by the Administrator as meeting minimum standards and requirements set forth in subsection (b), plus the cost-sharing and deductible requirements established by section 2141. Such procedure shall provide an opportunity for any insurance carrier to submit any

such plan, and such additional data as the Administrator finds necessary, to the Administrator for examination and for certification that such plan meets the standards and requirements of this title.

"(2) Certification of a health care benefit plan shall remain in effect, if the insurer files a complete and sworn statement with the Administrator by June 30 of each year stating that such a plan continues to meet such standards and requirements, and such additional criteria as the Secretary finds necessary to independently verify the accuracy of such statement. Where the Administrator determines such a plan meets the standards and requirements of this title, the Administrator shall authorize the insurer to have printed on such policy (but only in accordance with requirements and conditions as the Board may prescribe) an emblem which the Administrator shall cause to be designed for use as an indication that a policy has received the certification. The emblem shall carry the name of the Elderly Health Financing Authority. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received certification.

"(3) No private health care benefit plan shall be certified and no such plan may be issued bearing the emblem (described in paragraph (2)) until October 1 of the next year and annually thereafter. On and after such date, plans certified by

the Administrator may bear such emblem and recertification emblems, including plans which were issued prior to the date of the enactment of this title and subsequently certified. Carriers offering certified policies may notify current and potential holders of certified plans and of the availability of the plans.

"(b) The Administrator shall certify under this section any health care benefit plan, or continue certification of such a plan, only if such plan—

"(1) limits the liability of the insured for required services (as specified under paragraph 5)) to the catastrophic limit as established by cost-sharing and deductible requirements in section 2141,

"(2) limits the amount of coinsurance for which an insured would be responsible to 20 percent of the reasonable charge for a required service (as specified under paragraph (5)),

"(3) provides for systems or procedures of medical peer review and quality assurance,

"(4) states that if some or all of the services specified under paragraph (5) are not readily accessible to the insured, the plan will provide coverage for such services if performed by or under the direction of a physician, and

"(5) provides coverage for at least the following medically necessary services, without limitation (subject to paragraphs (1) and (2)):

"(A) Diagnostic, therapeutic, rehabilitative, preventive and consultation services provided by or under the direction of a physician, whether furnished in the office, the patient's home, a hospital, through hospital outpatient services, a skilled nursing facility, or elsewhere.

"(B) Services and medical supplies (including drugs and biologicals which cannot be self-administered) furnished incident to a physician's professional service (of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physician's bill).

"(C) Diagnostic imaging and laboratory services.

"(D) Radiation therapy services.

"(E) Routine medical examinations at least once every two years.

"(F) Pneumococcal vaccine and its administration, hepatitis B vaccine and its administration, and other vaccines determined by the Administrator to be cost-effective.

"(G) Inpatient hospital services and medical supplies (including nursing care, drugs, oxygen, blood, biologicals, diagnostic imaging, laboratory services, physical therapy services, occupational therapy services, and speech therapy services).

"(H) Outpatient hospital services and medical supplies, including nursing care, drugs, oxygen, blood, biologicals, diagnostic imaging, laboratory services, and physical therapy, occupational therapy and speech therapy, but not necessarily including drugs or biologicals, except those that cannot be self-administered.

"(I) Emergency services.

"(J) Alcohol and drug treatment services.

"(K) Durable medical equipment.

"(L) Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition.

"(M) Prosthetic devices which replace all or part of the mouth or of an internal body organ (including ostomy bags and supplies directly related to ostomy care), including replacement of such devices.

"(N) Leg, arm, back, and neck braces, artificial legs, eyes and arms, and including replace-

ments if required because of a change in the patient's physical condition.

"(O) Inpatient skilled nursing facility services and medical supplies (including nursing care, drugs, bioligicals, and physical, occupational and speech therapy services).

"(P) Home health services ordered by a physician and provided by a certified home health agency and services comparable to home health services that may be furnished by or under the supervision of a physician.

"(Q) Services and medical supplies furnished as an incident to home health services, including nursing care, blood, oxygen, physical therapy services, occupational therapy services, and speech therapy services, but not necessarily including drugs or biologicals, except those that cannot be self-administered.

"(R) Ambulatory physical therapy services, ambulatory occupational therapy services, and ambulatory speech therapy services ordered as part of a plan of care by a physician and regularly reviewed by a physician.

"SEC. 2152. (c) The Administrator shall prescribe such regulations as may be necessary for the effective, efficient,

and equitable administration of the certification procedure established under this section. The Administrator shall first issue final regulations to implement the certification procedure established under subsection (a) not later than 6 months after the date of the enactment of this title.

"(d) The Board shall establish such fiscal, reserve, and other requirements as necessary to assure the ability of carries to meet the contractual obligations of their plans.

"MARKETING OF HEALTH INSURANCE POLICIES

"(a) The Administrator shall establish a procedure whereby the proposed advertising and other marketing material for a health insurance policy shall be subject to review by the Administrator to determine whether it is false or misleading before such material is used by an insurer.

"(b) The Administrator shall prescribe by regulation standards for the effective, efficient, and equitable administration of the review procedure established under this section. Such regulations shall provide that if the Administrator fails to object to the proposed advertising or other marketing material within 60 days of receipt of such material, the insurer may immediately use such material.

DEFINITIONS

"SEC. 2153. For the purpose of this title—

"(1) the term 'private health care benefit plan' means a plan that directly provides health care services or a policy of health insurance offered by a private

entity to individuals who are entitled to a voucher under this title and which meets the minimum standards and requirements set forth in sections 2141, 2151, and 2152,

"(2) the term 'physician' means an individual holding a graduate degree of Doctor of Medicine or Doctor of Osteopathy who is licensed by the State where the individual practices to provide medical care,

"(3) the term 'catastrophic limit' means the full deductible and coinsurance required by section 2141,

"(4) the term 'reasonable charge' means the amount equal to the 90th percentile of physicians' customary or median charges in the area,

"(5) the term 'hospital facility and outpatient hospital services' only includes those services that meet standards set forth by the Joint Commission on Accreditation of Hospitals, or such other standards set pursuant to regulations under this title, and

"(6) the term 'skilled nursing facility services' means care provided through a facility meeting standards set pursuant to regulations under this title.".

SEC. 3. HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesig-

nating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.

"(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction an amount equal to the qualified contributions to a health individual retirement account of the individual for the taxable year.

"(b) LIMITATIONS.—

"(1) SUM OF CONTRIBUTORS' DEDUCTIONS NOT TO EXCEED $500 ANNUALLY PER ACCOUNT.—Any qualified contribution made for any taxable year with respect to any health individual retirement account shall not be deductible under subsection (a) to the extent that the contribution when added to the sum of all other qualified contributions, if any, previously made by contributors to the account for the taxable year exceeds $500.

"(2) ELIGIBLE CONTRIBUTORS.—Only the individual, the spouse of the individual, the parents of the individual, the children of the individual, and the guardian or guardians of the individual may contribute to a health individual retirement account established for the benefit of the individual.

"(c) SPECIAL RULES.—

"(1) ONE INDIVIDUAL PER ACCOUNT.—Only one individual may be the beneficiary of any health individual retirement account.

"(2) ONE ACCOUNT PER INDIVIDUAL.—If two or more health individual retirement accounts are established for the benefit of any individual, a deduction shall be allowed under this section only for contributions made to the account first established.

"(3) TIME WHEN CONTRIBUTIONS DEEMED MADE.—If a qualified contribution is made on account of an individual's taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (including extensions thereof), the individual shall be deemed to have made the contribution on the last day of such taxable year.

"(4) ADJUSTMENT OF DOLLAR AMOUNTS FOR INFLATION.—

"(A) AUTHORITY OF SECRETARY.—The Secretary shall, not later than October 1 of each year after enactment, revise the dollar amounts in subsection (b)(1) to arrive at the dollar amounts to apply with respect to taxable years beginning in the succeeding calendar year.

"(B) METHOD OF ADJUSTING DOLLAR AMOUNTS.—The dollar amounts applicable with

respect to taxable years beginning in the year succeeding any calendar year shall be calculated by multiplying the dollar amounts which apply to the calendar year by the sum of 1 and the net percentage change (if any) during the 12-month period ending on the July 31 of the calendar year in the Medical Care Component of the Consumer Price Index for all-urban consumers (published by the Department of Labor). If any amount determined under the preceding sentence is not a multiple of $10, such amount shall be rounded-up to the nearest multiple of $10.

"(5) DISTRIBUTION OF ACCOUNT ASSETS.—Amounts remaining in any health individual retirement account, on the day after the individual for whose benefit such account is established dies, shall revert to the individual's estate and be distributed in accordance with the directions of the individual.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) IN GENERAL.—Any amount received from a health individual retirement account (or a trust under subsection (e)(2)(B)) shall be included in the gross income of the recipient for the taxable year in which the amount is received, except as otherwise provided in this subsection.

"(2) DISTRIBUTION USED TO PAY HEALTH CARE EXPENSES.—Any amount paid from a health individual retirement account to cover health care expenses incurred by the individual for whose benefit the account is established shall not be included in the gross income of such individual for the taxable year in which such amount is paid.

"(3) ROLLOVER CONTRIBUTIONS.—Paragraph (1) shall not apply to any amount distributed out of a health individual retirement account to the beneficiary to the extent such amount is paid into another health individual retirement account of the beneficiary not later than the 60th day after the day of distribution. The preceding sentence shall not apply to any amount described therein received by the beneficiary if at any time during the 1-year period ending on the day of such receipt the beneficiary received any other amount described in the preceding sentence which was not includible in his gross income by reason of this paragraph.

"(4) EXCESS CONTRIBUTION RETURNED BEFORE DUE DATE OF RETURN.—Gross income does not include any excess contribution received from a health individual retirement account by the individual with respect to whom it is an excess contribution, if—

"(A) the excess contribution is received on or before the day prescribed by law (including extensions of time) for filing the individual's return for the taxable year,

"(B) no deduction is allowed under subsection (a) with respect to the excess contribution, and

"(C) there is received with the excess contribution the amount of net income attributable to the excess contribution.

Any net income described in subparagraph (C) shall be included in the gross income of the individual for the taxable year during which such excess contribution is made.

"(e) TAX TREATMENT OF HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—

"(1) EXEMPTION FROM TAX.—Each health individual retirement account shall be exempt from taxation under this subtitle. Notwithstanding the preceding sentence, such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc., organizations).

"(2) EFFECT OF ENGAGING IN PROHIBITED TRANSACTION.—

"(A) DISQUALIFICATION OF TRUST.—If the individual for whose benefit a health individual retirement account is established or any individual who contributes to such account engages in any transaction prohibited by section 4975 with respect to the account, the account ceases to be a health individual retirement account as of the first day of the taxable year of such individual during which such prohibited transaction begins.

"(B) ASSETS TREATED AS DISTRIBUTED.—If any trust ceases to be a health individual retirement account by reason of subparagraph (A), subsection (d)(1) shall apply to the trust assets as if the assets were received (on the first day of the taxable year during which the disqualification occurs) by the individual who engaged in the prohibited transaction.

"(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a health individual retirement account is established or any individual who contributes to the account uses any portion of the account as security for a loan, subsection (d)(1) shall apply to the portion so used as if the portion was received by the individual so using such portion during the taxable year.

"(f) ADDITIONAL TAX ON CERTAIN AMOUNTS INCLUDED IN GROSS INCOME.—

"(1) INCREASE IN TAX OF 10 PERCENT OF AMOUNTS IMPROPERLY USED.—If an amount is includible in the gross income of an individual for a taxable year by reason of subsection (d)(1), (e)(2), or (e)(3), the individual's tax liability under this chapter for such taxable year shall be increased by an amount equal to 10 percent of such included amount.

"(2) DISABILITY.—Paragraph (1) shall not apply to any distribution or income inclusion attributable to the taxpayer becoming disabled within the meaning of section 72(m)(7).

"(3) EXCEPTION INCIDENT TO DEATH.—Paragraph (1) shall not apply in the case of an asset received after the individual for whose benefit the health individual retirement account is established dies.

"(g) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

"(1) the account assets are held by a bank (as defined in section 408(n)) or another person who demonstrates, to the satisfaction of the Secretary, that the manner in which such person will administer the account will be consistent with the requirements of this section, and

"(2) the custodial account would, except for the fact that it is not a trust, constitute a health individual retirement account described in subsection (i)(2). For purposes of this title, in the case of a custodial account treated as a trust by reason of this subsection, the custodian of such account shall be treated as the trustee thereof.

"(h) REPORTS.—The trustee of any health individual retirement account shall make such reports regarding the account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by regulations.

"(i) DEFINITIONS.—For purposes of this section—

"(1) QUALIFIED CONTRIBUTION.—

"(A) IN GENERAL.—The term 'qualified contribution' means any amount of cash transferred to a health individual retirement account in the taxable year.

"(B) EXCEPTION.—The term 'qualified contribution' does not include any asset transferred

the qualified contributions of an individual for any taxable year exceeds the amount allowable as a deduction under subsection (a) with respect to the individual for such taxable year.''.

(b) DEDUCTION ALLOWED IN ARRIVING AT ADJUSTED GROSS INCOME.—Section 62(10) of such Code (relating to retirement savings) is amended to read as follows:

''(10) INDIVIDUAL RETIREMENT SAVINGS.—The deduction allowed by section 219 (relating to deduction for certain retirement savings) and the deduction allowed by section 220 (relating to health and individual retirement accounts).''.

(c) CONTRIBUTION NOT SUBJECT TO GIFT TAX.—Section 2503 of such Code (relating to taxable gifts) is amended by adding at the end thereof the following new subsection:

''(f) HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—Any transfer of assets by, or at the direction of, an individual to a health individual retirement account (as described in section 220(i)(2)) which is allowable as a deduction under section 220 shall not be treated as a transfer of property by gift for purposes of this chapter.''.

(d) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to indi-

vidual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by striking "**AND**" in the heading of such section,

(2) by striking "**ANNUITIES.**" and inserting "**ANNUITIES, AND HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.**" in the heading of such section,

(3) by striking "or" at the end of subsection (a)(1),

(4) by inserting after subsection (a)(2) the following:

"(3) a health individual retirement account (within the meaning of section 220(i)(2)), or", and

(5) by adding at the end the following new subsection:

"(d) HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—For purposes of this section, in the case of a health individual retirement account referred to in subsection (a)(3), the term 'excess contributions' means an excess contribution (within the meaning of section 220(i)(4)).".

(e) TAX ON PROHIBITED TRANSACTIONS.—

(1) Subsection (c) of section 4975 of such Code (relating to prohibited transactions) is amended by adding at the end the following new paragraph:

"(4) SPECIAL RULE FOR HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—The individual for whose benefit a health individual retirement account is established and each contributor to the account shall be exempt from the tax imposed by this section with respect to any transaction concerning the account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health individual retirement account by reason of section 220(e)(2)(A).".

(2) Paragraph (1) of section 4975(e) of such Code is amended by inserting ", a health individual retirement account described in section 220(i)(2)," after "described in section 408(a)".

(f) FAILURE TO PROVIDE REPORTS ON HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting "**OR ON HEALTH INDIVIDUAL RETIREMENT ACCOUNTS**" after "**ANNUITIES**" in the heading of such section; and

(2) by adding at the end of subsection (a) the following: "The person required by section 220(h) to file a report regarding a health individual retirement account at the time and in the manner required by such

section shall pay a penalty of $50 for each failure, unless it is shown that such failure is due to reasonable cause.".

(g) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of subtitle A of such Code is amended by striking the item relating to section 220 and inserting the following new items:

"Sec. 220. Health individual retirement accounts.
"Sec. 221. Cross references.".

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following new item:

"Sec. 4973. Tax on excess contributions to individual retirement accounts, health individual retirement accounts, certain 403(b) contracts, and certain individual retirement annuities.".

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

"Sec. 6693. Failure to provide reports on individual retirement accounts or annuities or on health individual retirement accounts.".

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions made in taxable years beginning after December 31, 1988.

"(4) SPECIAL RULE FOR HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—The individual for whose benefit a health individual retirement account is established and each contributor to the account shall be exempt from the tax imposed by this section with respect to any transaction concerning the account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health individual retirement account by reason of section 220(e)(2)(A).".

(2) Paragraph (1) of section 4975(e) of such Code is amended by inserting ", a health individual retirement account described in section 220(i)(2)," after "described in section 408(a)".

(f) FAILURE TO PROVIDE REPORTS ON HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—Section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting "**OR ON HEALTH INDIVIDUAL RETIREMENT ACCOUNTS**" after "**ANNUITIES**" in the heading of such section; and

(2) by adding at the end of subsection (a) the following: "The person required by section 220(h) to file a report regarding a health individual retirement account at the time and in the manner required by such

section shall pay a penalty of $50 for each failure, unless it is shown that such failure is due to reasonable cause.".

(g) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of subtitle A of such Code is amended by striking the item relating to section 220 and inserting the following new items:

"Sec. 220. Health individual retirement accounts.
"Sec. 221. Cross references.".

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4973 and inserting the following new item:

"Sec. 4973. Tax on excess contributions to individual retirement accounts, health individual retirement accounts, certain 403(b) contracts, and certain individual retirement annuities.".

(3) The table of sections for subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

"Sec. 6693. Failure to provide reports on individual retirement accounts or annuities or on health individual retirement accounts.".

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions made in taxable years beginning after December 31, 1988.

SEC. 4. TAX PROVISION.

(a) IN GENERAL.—Part I of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to tax on individuals) is amended by inserting after section 3 the following new section:

"SEC. 4. ELDERLY HEALTH FINANCING SURTAX.

"(a) RATE OF TAX.—In addition to other taxes imposed by this chapter, there shall be imposed on every individual (other than an estate or trust) for each year a tax as follows:

"(1) In the case of taxable years beginning in the first calendar year beginning after the date of the enactment of this section, the tax shall be equal to 1.75 percent of the amount of adjusted gross income (as defined in section 62) for such year.

"(2) In the case of a taxable year beginning in a subsequent calendar year, the tax shall be equal to 1.75 percent of such adjusted gross income, such percent adjusted by the Secretary to assure adequacy of funding of title XXI of the Social Security Act, based on the recommendation of the Elderly Health Financing Authority pursuant to section 2120(5) of such Act.

"(3) Congress reserves the authority to modify the tax rate specified in paragraph (2).

"(b) LIMITATIONS.—The tax imposed by this section shall not apply—

"(1) to any individual—

"(A) with an adjusted gross income for a taxable year beginning in a calendar year which does not exceed the per capita adjusted gross income of the lowest fifth percentile of taxpayers for taxable years beginning in the prior year, as determined by the Secretary, or

"(B) who is eligible in the taxable year for benefits under title XXI of the Social Security Act;

"(2) to the extent that an individual's adjusted gross income exceeds $100,000.

"(3) COST-OF-LIVING ADJUSTMENT.—

"(A) IN GENERAL.—In the case of a taxable year beginning in a calendar year that begins at least 1 year after the date of enactment of this section, paragraph (2) shall be applied by increasing the dollar amount contained therein by the cost-of-living adjustment for such calendar year.

"(B) COST-OF-LIVING ADJUSTMENT.—For purposes of subparagraph (A), the cost-of-living adjustment for any calendar year is the percentage (if any) by which—

"(i) the CPI for October of the preceding calendar year, exceeds

"(ii) the CPI for October 1988.

"(C) CPI.—The term 'CPI' means the Consumer Price Index for all urban consumers (vis. city average) published by the Department of Labor.

"(D) ROUNDING.—Any increase under paragraph (A) shall be rounded-up to the nearest multiple of $10."

(b) Chapter 2 of the Internal Revenue Code of 1986 (relating to the Self-Employment Contributions Act of 1954) is repealed.

(c) Chapter 21 of the Internal Revenue Code of 1986 (relating to the Federal Insurance Contributions Act) is amended—

(1) by repealing subchapter A (relating to tax on employees),

(2) by amending subsection (b) of section 3111 to read as follows:

"(b) ELDERLY HEALTH FINANCING EXCISE TAX.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121 (a) and (t)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid after December 31, 1988, the rate shall be 2.21 percent; and

"(2) with respect to wages paid after December 31, 1989, the rate shall be determined by the Elderly Health Financing Authority under section 2120 of the Social Security Act.".

SEC. 5. CONFORMING AMENDMENTS TO MEDICARE.

Title XVIII of the Social Security Act is amended as follows:

(1) The title of part A is amended by striking "AGED AND".

(2) Section 1811 is amended by striking clause (1), redesignating clauses (2) and (3) as clauses (1) and (2), respectively, and amending clause (2), as redesignated, to read as follows: "(2) certain individuals who do not meet the conditions specified in clause (1) but who are medically determined to have end stage renal disease.".

(3) Section 1817 is amended (A) in subsection (a); by striking paragraphs (1) and (2) and substituting for the dash the following: "the amount necessary to fund expenses incurred under part A of this program.", (B) by striking subsection (f), and (C) by redesignating subsections (g), (h), (i), and (j) as subsections (f), (g), (h), and (i), respectively.

(4)(A) Section 1818(a) is amended by striking paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(B) Section 1818(c) is amended by striking paragraph (1) and by redesignating paragraphs (2), (3), (4), (5), (6), and (7) as paragraphs (1), (2), (3), (4), (5), and (6), respectively.

(5) The title of part B of title XVIII is amended by striking AGED AND".

(6) Section 1831 is amended by striking "AGED AND".

(7) The first sentence of section 1836 is amended to read as follows: "Every individual who is entitled to hospital insurance benefits under part A is eligible to enroll in the insurance program established by this part.".

(8) Sections 1837(c) and 1837(d) are amended by striking "paragraph (1) or (2) of" in the first sentence, and by striking the second sentence.

(9) Section 1837(g)(1) is amended by striking "and upon attainment of age 65".

(10)(A) Section 1837(i)(1) is amended—

(i) by striking subparagraph (A);

(ii) redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B);

(iii) in subparagraph (A) (as redesignated), by striking "paragraph (1) or (2) of"; and

(iv) in the second sentence, by striking "paragraph (1) of".

(B) The first sentence of section 1837(i)(2) is stricken.

(11) Section 1838(1) is amended by striking "age 65" and inserting "eligibility under title XXI".

(12) Section 1838(b)((2)(A) is amended by striking "paragraph (1) or (2) of".

(13) Section 1838(c) is amended (A) by striking "paragraph (1) of", and (B) by striking "rather than on his having attained the age of 65".

(14) Section 1839(a)(1) is amended (A) by striking "age 65 and over", and (B) by striking the second and third sentences.

(15) Section 1839(a)(3) is amended (A) by striking "the smaller of—" and all that follows through "(B)", and (B) by striking the last sentence.

(16) Section 1839(a)(4) is repealed.

(17) Section 1839(b) is amended (A) by inserting a period after "re-enrolled" in the second sentence, and (B) by striking the remainder of that sentence.

(18) Section 1839(d) is amended by striking "his death;" and all that follows through the end of subsec-

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tion (d) and inserting "the earlier of his or her death or attaining eligibility under title XXI."

(19) Section 1839(e)(1) is amended by striking "age 65 and over".

(20) Section 1844(a)(1) is amended by striking subparagraphs (A) and (B) and inserting "a government contribution adequate to make up the difference between the aggregate premiums payable for covered beneficiaries and the amount necessary to fund the level of benefits covered under this title; plus".

(21) Section 1876(a)(5) is amended (A) by striking "of the sum of" and all that follows through "(B)", and (B) by striking "age 65" and inserting "entitlement to benefits under title XXI".

SEC. 6. EFFECTIVE DATE.

This Act becomes effective twelve months after the date of the enactment of this Act. The first January 1 occurring after such time shall be the beginning of the first coverage period as established in title XXI of the Social Security Act.

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